(2)

No. 09-24

IN THE SUPREME COURT OF THE UNITED STATES

AMERICAN FAMILY MUTUAL INSURANCE COMPANY and
AMERIPREFERRED PPO PLAN,

Petitioners,

v.

SHARON MONDRY

Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

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RESPONDENT'S BRIEF

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COUNTER-STATEMENT OF QUESTIONS PRESENTED

1. Whether ERISA §1024(b)(4) requires the administrator of an employee welfare benefit plan to furnish, upon request of a participant or beneficiary, the contract that delineates the authority, roles and responsibilities between the designated administrator of an employee welfare benefit plan and a third-party administrator in serving plan beneficiaries.

2. Whether plan documents supporting benefit determinations and claim decisions expressly cited and communicated to a plan participant or beneficiary function as "instruments under which the plan is established or operated" for the purposes of §1024(b)(4), giving rise to the plan administrator's legal requirement to provide them, upon request, to that participant or beneficiary.

PARTIES TO THE PROCEEDINGS

The Petitioners are the American Family Mutual Insurance Company and the AmeriPreferred PPO Plan, and Ms. Sharon Mondry is the Respondent.

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COUNTER-STATEMENT OF THE CASE

Respondent Sharon Mondry is the mother of Zev, a nine-year-old boy with an autism spectrum disorder. From birth through the age of thirteen months, Zev exhibited normal development, but over the course of months fourteen through seventeen, Zev lost all developed speech ability. Upon the recommendation of Zev's doctor, Ms. Mondry sought a diagnosis of Zev's condition by early childhood development specialists. The specialists, cognizant that most ground lost in speech development during early childhood is very difficult to recover and that speech development, in turn, influences learning ability, social skills, and a wide variety of other areas of development, recommended that Zev obtain speech therapy in order to minimize the impairment to his current and future speech capabilities. With very little of the critical period for language development in early childhood remaining, Ms. Mondry sought necessary services to maximize Zev's speech development.

For the eighteen months following his diagnosis, Zev received speech therapy through Wisconsin's Birth to Three Program, a federally-subsidized program for infants and toddlers with developmental delays and disabilities.[1] At the age of three, as Zev aged out of this program, Ms. Mondry anticipated the need to continue Zev's services with private insurance funds. Ms. Mondry contacted her employer, Petitioner American Family Mutual Insurance Company ("American Family"), to request a full copy of the plan requirements related to coverage of speech therapy

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[1] Pub. L. 99-457 (h) Education of the Handicapped Amendments of 1986, 20 USC 1470. Pub. L. 101-476 (1990) amended the name to Individuals with Disabilities Education Act.

services. American Family staff directed Ms. Mondry to the company's internal Website, where she reviewed the Summary Plan Description ("SPD") for the AmeriPreferred PPO Plan, American Family's self-funded health insurance plan for its employees.[2] Based on the language in the SPD defining "medical necessity," and her contact with American Family's Human Resources department, Ms. Mondry reasonably believed the Plan would cover Zev's speech therapy services.[3] In January 2003, shortly after his third birthday, Ms. Mondry enrolled Zev at a local speech language pathology clinic.

In June 2003, the clinic received a letter from a subsidiary of the Connecticut General Life Insurance Corporation ("CIGNA"), American Family's agent for purposes of claims administration, which denied coverage of Zev's speech therapy. The letter stated in part:

> The information provided does not meet plan language for speech therapy per CIGNA guidelines. Patient has expressive language skills delay and auditory comprehension skills impairment. Speech therapy to address this delay is educational or training. Speech therapy is not restorative.
> Based on CIGNA's Benefit Resource Tools Guidelines – Speech Therapy ["BIRT"].[4]

Ms. Mondry noted that the terms "expressive language skills delay," "auditory comprehension skills impairment," "educational or training," and "not restorative" did not appear anywhere in her Summary Plan document. Since Zev's

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[2] The AmeriPreferred PPO Plan is also a Petitioner.

[3] See Petition at 11 for the SPD's definition of "medically necessary."

[4] The Seventh Circuit and District Court opinions use both "BIRT" and "BRT" when referring to the Benefits Resource Tools Guidelines.

speech therapy appeared to her to be covered under the terms of the SPD, Ms. Mondry promptly replied to both CIGNA and American Family. She indicated her intent to appeal the denial and again requested a complete copy of her Plan documents. A month later, she received a response from a different CIGNA representative upholding the denial of benefits. This letter claimed that the Plan excluded coverage for Zev's treatment based on the "CIGNA Clinical resource tool [sic] for Speech Therapy" ("CRT").[5] Shortly thereafter, Ms. Mondry retained legal counsel and prepared for a Level Two appeal. During the wait for her second appeal, Ms. Mondry attempted to pay for Zev's speech therapy out of pocket, but the expense quickly became unmanageable. After four months, Ms. Mondry could no longer afford and therefore discontinued Zev's private speech therapy.

Over the next three years, Ms. Mondry *repeatedly* requested the documents that governed the plan and more specifically those that contained the language used to deny her claim.[6] Ms. Mondry directed her requests to both American Family and CIGNA until February 2004, when American Family instructed her to direct her requests specifically to CIGNA. R. 3, Ex. 13. In July 2004, over a year after Ms. Mondry's post-denial request, her counsel prevailed upon CIGNA to produce the CRT. Three months later, CIGNA produced the BIRT, which referenced the "CIGNA HealthCare Group Service Agreement 2001" ("GSA") as the "Applicable

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[5] Likewise, the courts refer to the Clinical Resource Tool as both "CIRT" and "CRT."

[6] The long history of Ms. Mondry's attempts to obtain the documents controlling her claim as well as her warnings about potential statutory penalties for failure to produce those documents is well summarized in the Seventh Circuit's opinion. Pet. App. at 6a-19a.

Plan Document." R. 40, Ex. D at 3. Separately, CIGNA's John Pendergast indicated that the GSA and other unnamed "criteria" would bear on the final decision on Ms. Mondry's appeal. R. 3, Ex. 17. Nearly three years after Ms. Mondry's original request and despite frequent and ongoing requests, American Family produced the GSA in September 2006 pursuant to discovery requests in these proceedings. Notably, the GSA gives American Family proprietary rights to all documents in CIGNA's possession, as well as the right to audit them at any time. R. 40 Ex. A at 4-5; *see also* Pet. App. at 46a-47a. Ms. Mondry's receipt of the GSA after discovery requests confirmed, as she and her counsel had believed from the start, that American Family's agency relationship with CIGNA gave it the authority to obtain the BIRT and CRT.[7] Hence, Petitioners' insistence that American Family could not obtain the CRT and BIRT from CIGNA is entirely false. *See, e.g.*, Pet. 10.

In June 2006, Ms. Mondry filed a complaint in federal court seeking redress for the statutory violations of ERISA as well as the unnecessary harms caused by the actions of American Family and its agent, CIGNA – including both significant financial harm to the family and irreparable developmental harm to Zev. The present claim centers on ERISA's requirement that "the [plan] administrator shall, upon written request of any participant or beneficiary, furnish a copy of the latest updated summary plan description, and the latest annual report, any terminal report, the bargaining agreement, trust agreement, contract, or other instruments under which the plan is established or operated." 29 U.S.C. §1024(b)(4).

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[7] CIGNA's counsel confirmed the same at oral argument before the Seventh Circuit.

The Seventh Circuit Court of Appeals overturned the trial court's initial dismissal of Ms. Mondry's complaint and granted her summary judgment against American Family on the present claim.[8] The Seventh Circuit's plain reading of the statute not only required production of the GSA, but the court also found that CIGNA explicitly cited the BIRT and the CRT to Ms. Mondry as the plan documents that controlled their decision on her claim. Therefore, the court concluded that the BIRT and CRT were "instruments under which the plan [was] established or operated," and American Family had a duty to disclose them to her upon request.

Petitioners argue that the Seventh Circuit's opinion conflicts with its own precedent, the law of the other Circuits, and the broad principles underlying ERISA as recognized by this Court. They ask this Court to review the Seventh Circuit's opinion for alleged errors. Ms. Mondry maintains that Petitioners' arguments are wholly without merit, but nevertheless agrees that the issue at hand is an important one bearing this Court's consideration. For the reasons herein, Ms. Mondry therefore respectfully requests that this Court consider and ultimately affirm the Seventh Circuit's reasoned judgments.

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[8] The Seventh Circuit held Ms. Mondry is entitled to statutory penalties to be determined on remand. The three years of stonewalling by CIGNA and American Family in the face of dozens of requests by both Ms. Mondry and her counsel (our count totals forty-one requests) for the production of documents demonstrates the need for a "marginal deterrent." *Zaice v. Vest*, 916 F.2d 1204, 1210-11 (7th Cir. 1990). Neither American Family nor CIGNA has yet released to Ms. Mondry some documents, referenced as "other criteria" by CIGNA employee John Pendergast. Pet. App. 31a, n.6.

ARGUMENT

Petitioners present an imaginative variety of arguments on the merits of the Seventh Circuit's holdings and those arguments command a response. Here, however, we confine ourselves to addressing Petitioners' arguments for granting a writ of certiorari and providing our own, except where our arguments on the merits – or the faults in Petitioners' – bear on whether this Court should grant certiorari.

I. PETITIONERS' ARGUMENTS FOR GRANTING CERTIORARI REST LARGELY ON MISSTATEMENTS OF THE SEVENTH CIRCUIT'S HOLDING AND PRIOR PRECEDENT

A. The Seventh Circuit Resolved the §1024(b)(4) Dispute with Petitioners as to Whether the CRT and BIRT Constituted "Plan Documents" Subject to the Disclosure Requirements of the Rule.

Petitioners' characterization of Ms. Mondry's dispute, as "seeking penalties from American Family for failing to promptly provide a copy of CIGNA's internal guidelines so that she could pursue a full and fair review of the denial of her claim," is clothed in the language of 29 U.S.C. §1133(2). Contrary to Petitioners' recent assertion, this is not a case about denial of full and fair review or deficiencies in a particular appeal process. This is a clear-cut case about preserving transparency and upholding the plan beneficiary's right to know the standards by which her claim will be judged by the plan's administrators. Petitioners' reliance on §1133 under these circumstances is misguided and without merit, as the course of litigation has stemmed from the appropriate application of §1024(b)(4)'s disclosure requirements. The purpose of this disclosure provision is to "ensure[ ] that 'the individual participant knows exactly where he stands with respect to the plan[.]' " *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 118, 109 S. Ct. 948, 958 (1989)

(quoting H.R. Rep. 93-533, p.11 (1973), U.S. Code Cong. & Admin. News 1978, p. 4649). Knowing where one stands with respect to a plan includes having the information necessary to determine one's eligibility for benefits under the plan, *see Davis v. Featherstone*, 97 F.3d 734, 737 (4th Cir. 1996), to understand one's rights under the plan, *Bartling v. Fruehauf Corp.*, 29 F.3d 1062, 1070 (6th Cir. 1994), to identify the persons to whom management of plan funds has been entrusted, *Hughes Salaried Retirees Action Comm. v. Admin. of Hughes Non-Bargaining Retirement Plan*, 72 F.3d 686, 690 (9th Cir. 1995) (en banc) (quoting S. Rep. No. 93-127, 93d Cong., 2d Sess. (1974), *reprinted in* 1974 U.S. Code Cong. & Admin. News 4838, 4863), and to ascertain the procedures one must follow in order to obtain benefits. *Id.*

Petitioner American Family's claim at oral argument that Ms. Mondry's dispute is a "garden variety claims denial" and its assertion here that American Family's duty to provide the CRT and BIRT arose exclusively under 29 U.S.C. § 1133(2) (Pet. 14-15, 19-21, 24-28) is seriously misguided. Petitioners endorse the exact type of bait and switch tactics that CIGNA and American Family subjected Ms. Mondry to from day one. First, Ms. Mondry's claim was inappropriately denied. When she inquired into the basis for denial, American Family and its agent, CIGNA, became evasive and supercilious. Ms. Mondry was held at arm's length for as long as possible. Ms. Mondry, soon represented by counsel, nevertheless persevered where others might simply have abandoned their claims. When Ms. Mondry's legal investigation exposed the gross incompetence of the Plan's principal

actors, CIGNA—after nearly two years—abruptly changed its position and became eager to move forward with a "full and fair" appeal hearing. The process proposed by Petitioners is self-serving; and the consequences for prematurely initiating a §1133 review for plan beneficiaries is severe. Petitioners propose that an administrator may adjudicate claims using unpublished, even inapplicable rules, and deny the participant access to those rules. The administrator may then escape any penalty by simply approving claim payment when it becomes clear the participant will not abandon her claim. The participant receives her benefits due under the plan, but is left with no redress for the costs incurred in pursuing her rightful claim. Such costs may include loss of the time value of money paid by the participant in satisfaction of denied claims; lost opportunities to make informed health care decisions; irretrievably lost benefits of ongoing care; personal anxiety and frustration; and the expenses of legal representation.

Ms. Mondry did not seek relief under §1133(2), and did not buy into the Plan's bait and switch tactic. Ms. Mondry, in fact, prevailed at her Level Two appeal largely due to the production of the ultimately specious BIRT and CRT. The harm that Ms. Mondry suffered was not the denial of full and fair review, but rather the extraordinary delay in the production of the CRT and BIRT that were key to success in her appeal hearing.

B. The Seventh Circuit Held that §1024(b)(4) Requires Disclosure of Only Those Guidelines Expressly Cited to a Beneficiary as Controlling Her Claim

Petitioners mischaracterize the Seventh Circuit's opinion as expansive, suggesting that it would require disclosure under §1024(b)(4) of every piece of information relied upon in ruling on a claim. Pet. ii, 33-34. Petitioners go so far as to suggest the Seventh Circuit would require plan administrators to produce dictionaries and medical treatises. Pet. 33.

Contrary to Petitioners' assertions, the Seventh Circuit explicitly rejected the notion that it required production of all documents relied upon in ruling on a claim: "Our holding is a narrow one. **We are not saying that simply because a claims administrator relies on a set of internal guidelines, rightly or wrongly, in denying a claim for benefits, those documents become subject to mandatory production under section 1024(b)(4).**" Pet. App. 43a (emphasis added). Rather, the Seventh Circuit held that the critical factor subjecting the CRT and BIRT to disclosure under §1024(b)(4) was their having been *expressly cited* to Ms. Mondry and treated as "the equivalent of plan language" in denying her claim.[9] *Id.*

Petitioners' first Question Presented to this Court reflects their misreading and mischaracterization of the Seventh Circuit's opinion. Petitioners ask this Court to consider whether claims handling guidelines "morph into documents under which the plan is operated if **relied upon in error** by a third party claims

[9] "CIGNA did not treat the BIRT and CRT as private guidelines that merely illuminated plan language. CIGNA expressly cited both documents as the basis for its decision to deny Mondry's claim for benefits and invited Mondry's reference to them." *Id.*

administrator." Pet. ii (emphasis added). Neither the Seventh nor any other Circuit has reached that conclusion. Ms. Mondry's second Counter-Statement of the Questions Presented, *supra* ii, correctly explicates the issue at hand. The key factor subjecting the CRT and BIRT to disclosure to Ms. Mondry under §1024(b)(4) was that American Family's agent, CIGNA, treated and expressly cited these documents to her as the plan documents that determined the scope of her coverage and controlled her claim.

C. The Seventh Circuit's Opinion is Consistent With the Settled Precedent that Beneficiaries Must Have Access to Language Cited to Them as Defining Plan Benefits

Petitioners claim the Seventh Circuit's holdings conflict with its own settled precedent. Specifically, this line of Petitioners' argument centers on the Seventh Circuit's opinions in *Ames v. Am. Nat'l Can Co.*, 170 F.3d 751 (7th Cir. 1999); *Egert v. Connecticut General Life Ins. Co.*, 900 F.2d 1032 (7th Cir. 1990); and *Fritcher v. Health Care Service Corp.*, 301 F.3d 811 (7th Cir. 2002). Petitioners cite *Ames* to establish that §1024(b)(4) requires disclosure only of documents that formally govern the establishment or operation of a plan, and to argue that the CRT, BIRT, and GSA fall outside its scope. Petitioners cite *Egert* and *Fritcher* for the propositions that guidelines and service agreements, respectively, do not constitute plan documents.

Petitioners' argument that requiring disclosure of the BIRT and CRT conflicts with *Ames* relies on their misstatement of the Seventh Circuit's holding as requiring the disclosure of all documents relied upon in evaluating a claim. See Pet.

23-24, 27. In *Ames*, as the court noted, the Seventh Circuit "rejected a broad construction of the catch-all language [in §1024(b)(4)] that would sweep within its reach all documents relevant to a plan and instead agreed with those courts which have construed the catch-all language narrowly to reach only those documents that formally govern the establishment or operation of a plan."[10] Pet. App. 32a (quoting *Ames*, 170 F.3d at 758-59). As the court explained, however, the emphasis here on the *express citation* to participants and beneficiaries of external documents as defining plan benefits distinguishes its holding here from the broad construction of §1024(b)(4) rejected in *Ames*.[11]

Petitioners further argue that the Seventh Circuit broke with *Ames* in requiring disclosure of the GSA. Pet. 16, 37-38. Here, Petitioners incorrectly read the opinion of the Seventh Circuit, which recognizes that §1024(b)(4) *expressly requires* disclosure of any "contract ... under which a plan is established or operated." Pet. App. 32a-33a. Whether it falls within the scope of the catch-all language is irrelevant. Since the GSA is a contract that defines the respective roles of American Family and CIGNA as the plan and claims administrators to serve the needs of plan beneficiaries, it qualifies as a contract under which the plan was

[10] The "catch-all language" the court refers to here is §1024(b)(4)'s provision that the documents administrators must disclose upon request include unspecified "other instruments under which the plan is established or operated."

[11] In *Ames*, plaintiffs initially requested that the plan administrator disclose anything that "could reasonably be anticipated to have an impact on the benefits provided," and later provided a more specific request for a broad array of documents. *Id.* at 758-59.

operated, and easily qualifies for §1024(b)(4) disclosure even under *Ames*. Pet. App. 31a-33a. As the Seventh Circuit held, "When the administration of a plan is divided, as is often the case," "the extent of each administrator's authority is basic information that a plan participant needs to know." Pet. App. 32a-33a. *See, e.g.*, *Rud v. Liberty Life Assur. Co. of Boston*, 438 F.3d 772, 774 (7th Cir. 2006).

Petitioners' characterizations of *Egert* and *Fritcher* are correct but point to an issue not in question in the present matter. These cases make clear that language found in guidelines and service agreements not provided to plan participants and beneficiaries *must not be used to limit their rights and benefits*. *Egert* reversed the denial of plaintiff's medical benefits, holding it arbitrary and capricious to deny benefits based on language conflicting with the terms of the SPD and found in guidelines not provided to plaintiff. 900 F.2d at 1038. *Fritcher* rejected defendant's argument, based partly on contractual language according it "discretion" in paying claims, that its denial of plaintiff's benefits should have been reviewed under an arbitrary and capricious standard. 301 F.3d at 817. As the Court noted in *Fritcher*, the service agreement was "not a 'plan document' for purposes of holding its terms against a plan participant or beneficiary." *Id.* Nothing in these cases, however, exempts documents from disclosure under §1024(b)(4) when the language they contain is treated as plan language and expressly cited to participants and beneficiaries as defining the scope of their coverage.

Understood properly, *Egert* and *Fritcher* reflect the same concern for a transparent process that underlies the Seventh Circuit's opinion here: plan

participants and beneficiaries have a right to access the language upon which their claims and appeals will be judged. As Petitioners and this Court recognize, "[o]ne of ERISA's central goals is to enable plan beneficiaries to learn their rights and obligations at any time." Pet. 12 (quoting *Curtis-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 83 (1995)). In this light, the Seventh Circuit's opinion here is not antithetical to its prior precedent, but rather a logical extension.

In sum, Petitioners present this Court with largely specious ground for granting a writ of certiorari. Even if conflicting opinions within a Circuit were ground for granting certiorari, there exists no conflict here for this Court to resolve. There are, instead, other compelling reasons for this Court to address the scope of the disclosure requirement in §1024(b)(4). For the reasons below, and notwithstanding the foregoing, Ms. Mondry therefore supports Petitioners' request for certiorari.

II. The Case Law on §1024(b)(4) Demonstrates the Need for Guidance From This Court

A. The Scope of Plan Administrators' Required Disclosure of "Other Instruments Under Which the Plan is Established or Operated" is Unclear

Courts have long grappled with the question of how broadly to interpret the catch-all language in §1024(b)(4) requiring plan administrators to furnish participants and beneficiaries with "other instruments under which the plan is established or operated." After the Sixth Circuit established a presumption in favor of disclosure in *Bartling*, 29 F.3d at 1062, several other Circuits issued decisions favoring a narrower interpretation of the statutory text, each applying a slightly

different rule or standard to define the universe of documents required to be disclosed. Hence, while most Circuits–including the Seventh–favor a relatively narrow interpretation of §1024(b)(4), it remains unclear precisely what rule or standard to apply in specific cases.

Noting that Congress intended ERISA's disclosure requirements to ensure participants' and beneficiaries' access to information defining their rights and obligations, the Sixth Circuit held in *Bartling* that "all other things being equal, courts should favor disclosure where it would help participants understand their rights." *Bartling*, 29 F.3d at 1070. In keeping with this presumption in favor of disclosure, the Sixth Circuit held that §1024(b)(4) required the plan administrator to provide plaintiffs with actuarial valuation reports and an internal benefit calculation procedure as "other instruments under which the plan [was] established or operated." *Id.* at 1069-71.

In *Hughes*, 72 F.3d at 686, the Ninth Circuit, sitting en banc, overturned the reading of §1024(b)(4) adopted earlier by its three-judge panel in the same proceedings in favor of a narrower interpretation. The court "decline[d] to interpret [§1024(b)(4)] to require general disclosure," *Id.* at 691, reasoning that the "other instruments" contemplated by §1024(b)(4) must be limited to those similar to the specific documents listed – in other words, those that "provide individual participants with information about the plan and benefits." *Id.* at 689-90. Further, quoting directly from the legislative history, the Ninth Circuit held that "the documents contemplated by [§1024(b)(4)] are those that allow "the individual

participant [to] know[] exactly where he stands with respect to the plan," including "what benefits he may be entitled to" and "what circumstances may preclude him from obtaining benefits[.]" *Id.* at 690. The document plaintiffs sought, a list of the names and addresses of retired plan participants, did not fall within this description, so the Ninth Circuit held that its disclosure was not required.

The Second Circuit reasoned along similar lines in *Bd. of Trustees of the CWA/ITU Negotiated Pension Plan v. Weinstein*, 107 F.3d 139 (2nd Cir. 1997). Like the Ninth Circuit in *Hughes*, the Second Circuit invoked the "familiar principle of statutory construction that words grouped in a list should be given related meaning." Applying *ejusdem generis*, the court distinguished formal governing documents of the kind contemplated by §1024(b)(4) – including summary plan descriptions, which "describe, *inter alia*, 'circumstances which may result in disqualification, ineligibility, or denial or loss of benefits'" – from the "far broader categories of documents" required to be disclosed in other sections of ERISA, such as that "authoriz[ing] the Secretary of Labor to 'require the submission of [a plan's] *reports, books, and records.*'" Id. at 142-43 (citing 29 U.S.C. §§1022(b), 1134(a)(1)). In direct opposition with *Bartling*, the Second Circuit held that the actuarial valuation reports that defendant sought fell into the latter category and that disclosure was not required under §1024(b)(4).

The Fourth Circuit issued both a direct challenge to *Bartling* and a partial challenge to *Hughes* in *Faircloth v. Lundy Packing Co.*, 91 F.3d 648 (4th Cir. 1996). In *Faircloth*, the Fourth Circuit declared §1024(b)(4) "clear and unambiguous,"

holding that "the language 'other instruments under which the plan is established or operated' encompasses formal or legal documents under which a plan is *set up or managed*." *Id.* at 653 (emphasis added). Finding no ambiguity in the plain text, the Fourth Circuit declined to consider ERISA's legislative history in interpreting the scope of §1024(b)(4)'s disclosure requirement. Applying its plain-text reading of §1024(b)(4), the Fourth Circuit proceeded to reject *Bartling*'s presumption favoring disclosure, finding nothing on the face of the statute to support it. *Id.* at 654. Similarly, the court also rejected *Hughes* to the extent that its interpretation of §1024(b)(4) "encompasses documents other than those under which a plan is set up or managed." *Id.*

The Seventh Circuit's *Ames* case, one of the principal cases upon which Petitioners rely, appears to carry *Faircloth*'s restrictive view on §1024(b)(4) disclosures a step further still. In *Ames*, the Seventh Circuit cited *Faircloth* and *Weinstein* in favor of a conclusion that neither case compels: that "the use of the term 'instruments' implies that the statute reaches only *formal legal documents* governing a plan." 170 F.3d at 758 (emphasis added). In fact, *Faircloth* concluded that the catch-all language "encompasses formal *or* legal documents under which the plan is established or operated," 91 F.3d at 653 (emphasis added). *Weinstein*, like *Hughes*, relied on the distinction between documents defining plan benefits on the one hand, and ministerial documents such as reports, books, and records on the other. Neither *Faircloth* nor *Weinstein* suggested the rule that documents *must be legally binding* to qualify as "other instruments under which the plan is established

or operated," as *Ames* implied and as the First Circuit's *Doe v. Travelers Ins. Co.*, decided around the same time, explicitly held. 167 F.3d 53 (1st Cir. 1999).

In sum, while the Circuits have rejected an interpretation of §1024(b)(4) that would require disclosure upon request of all documents relevant to a plan, the standard by which a document is judged to fall within the statute's catch-all language is far from clear. Some Circuits combine a reading of the legislative history and *ejusdem generis* to limit the scope of the disclosure requirement to documents containing information regarding beneficiaries' rights and benefits; others adopt a strict plain meaning approach to limit disclosure to formal and/or legally binding documents. Meanwhile, *Bartling*'s presumption in favor of disclosure "where it would help participants understand their rights," 29 F.3d at 1070, remains binding authority in the Sixth Circuit and persuasive authority in the others. *Faircloth*'s view of §1024(b)(4) as "clear and unambiguous" notwithstanding, given the hodgepodge of precedents in the case law, it is unsurprising that two Circuits considering precisely the same question and relying largely on the same body of authority could draw opposite conclusions.

B. The First and Seventh Circuits Disagree on Whether §1024(b)(4) Requires Plan Administrators to Disclose Plan Documents Expressly Cited as Controlling the Plan Beneficiary's Claims.

The Seventh Circuit's decision stands in contrast to the First Circuit's opinion in *Doe*. In overturning the district court's holding that §1024(b)(4) required disclosure of a set of "Medical Necessity Guidelines" cited in defendant's initial denial letter to plaintiff, the First Circuit noted that the Guidelines "would likely

have been quite helpful to Doe and her doctors in arguing for inpatient treatment" and might reasonably have been considered "other instruments under which the plan is established or operated." *Id.* at 59-60. Instead, however, citing *Faircloth* and *Hughes*, the First Circuit held that only *legally binding* documents are subject to disclosure under §1024(b)(4). "[T]his language is more reasonably directed to provisions such as those contained in the policy itself that describe the plan *and legally obligate Travelers*." *Id* at 60 (emphasis added). Since "Travelers was not bound to use [the Guidelines,] nor did patients have any legal rights under them," Travelers was not obligated to disclose them to plaintiff. The court reached this result despite neither *Faircloth*'s nor *Hughes*' having suggested that *only* legally binding documents are subject to disclosure under §1024(b)(4)'s catch-all language, and despite Travelers' having expressly cited the Medical Necessity Guidelines as controlling plaintiff's claim. *Id.*

In the present case, in direct opposition to *Doe*, the Seventh Circuit held that "the fact that neither document was actually binding on CIGNA ...is beside the point." Pet. App. 41a. Instead, the key factor is CIGNA's having treated the CRT and BIRT as plan language and expressly cited them to Ms. Mondry as *the* documents they relied upon in denying her claim. Pet. App. 43a. In effect, since CIGNA treated the BIRT and CRT as superseding the actual, legally binding plan language and cited them to Ms. Mondry as such, they qualify as documents under which the plan was established or operated.

Hence, despite relying largely on the same body of precedent, the First and Seventh Circuits reached opposite conclusions on whether §1024(b)(4) can require plan administrators to disclose documents supporting benefit determinations and claim decisions when those documents are cited to plan participants and beneficiaries as controlling their claims. Had *Doe* followed the Seventh Circuit's rule, the plan administrator would have been required to disclose the Medical Necessity Guidelines. Conversely, the First Circuit, under a strict reading of *Doe*, would not have required disclosure of the CRT and BIRT to Ms. Mondry, despite CIGNA's false representation of them in her claim denial as plan documents.

To be sure, the present case may be distinguished from *Doe* on the facts. The district court opinion in *Doe*, 971 F.Supp. 623, 639-40 (D.Mass. 1997), shows that plaintiff made only one request for the Medical Necessity Guidelines, as opposed to Ms. Mondry's numerous requests over three years; that plaintiff's request was framed ambiguously, in contrast with Ms. Mondry's explicit requests for the CRT, BIRT, and GSA; and that plaintiff, unlike Ms. Mondry's young son Zev, was able to borrow money in order to continue her needed treatment. Moreover, nothing in the *Doe* opinions indicates that the plaintiff suffered irreparable harm as a result of defendant's improper denial of benefits, whereas the loss of speech therapy services during a critical period of early childhood development permanently impaired Zev's overall communicative ability.

The Seventh Circuit's holding here comports better than *Doe* with the range of prior precedent taken as a whole. Aside from *Doe*, only under the Fourth Circuit's

standard in *Faircloth*, which limits the disclosure requirement to documents under which the plan is "set up or managed," would disclosure of the CRT and BIRT have been uncertain. *Doe* conflicts on its face with *Bartling*'s presumption in favor of disclosure, and represents a far stricter standard than that embodied in either *Hughes* or *Weinstein*. Indeed, in explicitly limiting §1024(b)(4)'s disclosure requirement strictly to legally binding documents, *Doe* surpassed even *Faircloth* to adopt the most restrictive interpretation put forward by any Circuit Court of Appeals. By contrast, the Sixth Circuit's rule in favor of disclosure "where it would help participants understand their rights" would undoubtedly require disclosure of the BIRT and CRT. *Bartling*, 29 F.3d at 1070. Moreover, their disclosure would likely be required under the standard adopted by the Second Circuit in *Weinstein* and the Sixth Circuit in *Hughes*, which limits the scope of required disclosure to documents that define beneficiaries' rights and benefits. In short, the Seventh Circuit's opinion represents a middle-of-the-road view in the broad universe of §1024(b)(4) precedents.

Finally, the rule applied in the present case adheres more faithfully than *Doe*'s to Congress' intent to "ensure[ ] that 'the individual participant knows exactly where he stands with respect to the plan[.]'" *Firestone*, 489 U.S. at 118, (quoting H.R. Rep. 93-533, p. 11 (1973), U.S. Code Cong. & Admin. News 1978, p. 4649). As the Seventh Circuit recognized, "to hold otherwise"–as the First Circuit did in *Doe*–"would allow a claims administrator to 'hide the ball' from the participant,

depriving her of access to the very documents that the claims administrator is saying are dispositive of her claim." Pet. App. 43a.

C. Most Circuits' Interpretations of §1024(b)(4) Conflict With the Department of Labor's Interpretation

The Department of Labor takes the position that a request for documents relied upon in promulgating an adverse claim determination does, in fact, trigger mandatory disclosure obligations under §1024(b)(4). Dep't of Lab. Adv. Op. 96-14A (July 31, 1996). In clarifying the "other instruments" provision, the DOL stated that the phrase should be interpreted to encompass any internal procedures, rules, guidelines, protocol, etc. (*i.e.* "instruments under which the plan is established or operated"). The DOL further instructed that procedure manuals or other materials outlining procedures to be applied in determining whether a participant or beneficiary is entitled to benefits should be provided.[12] *Id. Teen Help, Inc. v. Operating Engineers' Health and Welfare Trust Fund* No. C 98-2084, slip op. (N.D. Cal. Aug. 24, 1999) deferred to that published opinion of the DOL in holding that internal guidelines relied upon in reaching an adverse determination constituted documents subject to the disclosure requirements of §1024. *Id.* at 4 – 5.[13]

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[12] Dep't of Lab. Adv. Op. 96-14A (1996) stated that a schedule of fees used for reimbursement of medical care costs under a health care plan was a document that must be disclosed to plan participants under ERISA. The plan administrator had denied access to the fee schedule, stating that it was proprietary. The DOL found that the schedule of usual and customary fees was a document that directly affected the benefits of the plan.

[13] The court deferred to the Advisory Opinion as reasonably supporting disclosure of the utilization review criteria used for determining medical necessity due to its consistency with Congressional

This Court should afford *Chevron*-level deference to the DOL's interpretation of the "other instruments" language of §1024(b)(4). *Chevron U.S.A. Inc. v. Natural Res. Defense Council, Inc.*, 467 U.S. 837, 844, 104 S.Ct. 2778, 2782, 81 L.Ed.2d 694 (1984); see also *United States v. Mead*, 533 U.S. 218, 226-27, 230 n.12, 121 S.Ct. 2164, 2171, 150 L.Ed.2d 292 (2001) (holding that *Chevron* provides the appropriate evaluative standard where Congress has given an agency the authority to bind regulated parties with "the force of law" and the agency has "exercised that authority," and identifying legislative rules as a prototypical example of *Chevron*-eligible agency action).

The two-prong test of *Chevron* requires that a court first determine whether Congress has directly spoken to the precise question at issue, in which case the inquiry ends, and if the intent of Congress is unclear, e.g., if the statute is silent or ambiguous with respect to the specific issue, whether the agency's regulation is based on a permissible construction of the statute. *Id.* at 844. A plain reading of ERISA suggests that plan participants and beneficiaries should have access to documents that directly affect their benefit entitlements under an employee benefit plan. To clarify which interpretation courts should follow, 29 USC §1029(c) provides that the Secretary of Labor may regulate what other documents must be furnished. Further, 29 USC §1135 states that the Secretary has the authority to "prescribe

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intent to let participants know "exactly where (they) stand with respect to the plan—what benefits he may be entitled to." *Id.* (citing S. Rep. No. 127, 93rd Cong., 2nd Sess. 28 (1973)).

such regulations as he finds necessary or appropriate to carry out the provisions of this Title."

Not only does the statute reveal an express delegation of authority to the DOL to make rules carrying the force of law, but the DOL has also promulgated a rule pursuant to that authority to determine that plan participants and beneficiaries should have access to documents that directly affect their benefit entitlements under an employee benefit plan. In amendments to 29 C.F.R. 2560.503-1, the regulation governing, *inter alia*, notice and disclosure requirements during the claims procedure, the DOL gave the Advisory Opinion the force of law by maintaining, "It is the Department's view that such internal rules, guidelines, protocols, etc. [that served as a basis for the adverse benefit determination] are 'instruments under which the plan is established or operated' within the meaning of section 1024(b) of the Act and as such must be furnished to participants and beneficiaries upon written request. See Advisory Opinion 96-14A." 65 Fed. Reg. 70250-52 (Nov. 21, 2000).[14]

The Third Circuit, applying *Mead*, held that putting the regulation at issue through public notice and comment is "a move that is indicative of agency action that carries the force of law," making *Chevron*-level deference appropriate.

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[14] Plan administrators' notice requirements under 29 C.F.R. § 2560.503-1(f) were clarified with the 2002 amendments to expressly require a "statement...that a copy of such rule, guideline (etc.) will be provided free of charge...upon request." 29 C.F.R. § 2560.503-1(g). Please note the 2002 amendments renumbered the subsections of this regulation. The section citing the plan administrator's notice requirements became (g).

Swallows Holding, Ltd. v. Commissioner of Internal Revenue, 515 F.3d 162, 169 (2008)(citing *Cleary v. Waldman*, 167 F.3d 808 (3d Cir. 1999)). In September of 2000, the DOL issued a Request for Public Comment regarding disclosure obligations under ERISA. 65 Fed. Reg. 55857-61 (Sept. 14, 2000).[15] The Department specifically cited Advisory Opinion 96-14A in addition to the *Teen Help* decision in its request. The DOL's position favoring disclosure of documents relied upon in claims determinations was not only subject to public comment, but the scope of commentary and the basis for DOL's decisions are well articulated in the final rule publication. 29 C.F.R. § 2560.503-1(g) (2002).

Advisory Opinion 96-14A is clearly consistent with the regulations of the Department and espouses an inherently reasonable interpretation of the "other documents" provision. This places the Advisory Opinion squarely within the requirements of *Chevron* deference for this Court.

Further, the courts have deferred to the DOL's interpretation of its own regulations as expressed in Advisory Opinions unless the interpretation is "plainly erroneous or inconsistent with the regulation." *Chevron*, 467 U.S. at 844. In *Herman v. NationsBank Trust Co.*, despite NationsBank's claim that the court should not give *Chevron* deference to the Secretary's interpretation of ERISA where that interpretation is espoused only in litigation documents and opinion letters and not in formal regulations, the court deferred to the Secretary's interpretation after concluding that it was reasonable. 126 F.3d 1354 (11th Cir. 1997), *cert. denied*, 525 U.S. 816 (1998). In *Falken v. Glynn County, Georgia*, 197 F.3d 1341 (11th Cir. 1999)

[15] The Request for Public Comment was extended by 66 Fed. Reg. 7513 (Jan. 17, 2001).

the court applied *Chevron* deference to the DOL's interpretative rule, claiming the interpretation used by the Secretary of Labor was "consistent with the regulations [29 C.F.R. § 553.201(a)]."Due to the presence of notice-and-comment rulemaking and reliance on the Advisory Opinion for regulatory amendments, the DOL opinion has the force and effect of law and possesses the Congressional delegation necessary for *Chevron* deference.

This Court has not interpreted the scope of the term "other instruments" in §1024(b)(4).[16] In the present case, the Seventh Circuit has taken a clearer step toward the DOL's opinion on how to interpret the "other instruments" language, while promulgating a holding less expansive than the reasonable regulatory interpretation espoused by the DOL. Ms. Mondry's case presents this Court with an opportunity to harmonize the standard under which documents are subject to mandatory disclosure with the guidance of the Department of Labor.

III. The Seventh Circuit's Holding Serves the Important Goal of Promoting Transparency in the Administration of Employee Benefit Plans

A. The Seventh Circuit's Holding is Eminently Workable

Petitioners posit that the decision by the Seventh Circuit would force plan administrators into a dismal swamp of confusion and possible deception and would "[cause] *claims administrators to avoid referencing internal guidelines when denying claims.*" Pet. 18. To the contrary, the Seventh Circuit decision provides

[16] *See* discussion *supra* Part II.B. *See also, Allinder v. Inter-City Products Corp.*, 152 F.3d 544, 549 (6th Cir. 1998), cert. denied, 525 U.S. 1178 (1999); *Brown v. American Life Holdings, Inc.*, 190 F.3d 856, 861 (8th Cir. 1999).

clear guidance to plan administrators and claims administrators; offers a transparent process for plan beneficiaries; and conforms more closely to the statute and DOL guidance.

Claims administrators cannot represent and communicate plan documents to plan beneficiaries as legally binding documents and then recast them as internal documents. If such documents are so shielded, claims administrators will have much more power than authorized by Congress or the DOL, and will undermine the fair, equitable and transparent process demanded by the public. One can imagine scenarios of plan beneficiaries denied benefits based on secret information known only to unscrupulous or incompetent plan or claims administrators. Public confidence in health benefits claim determinations, already low, will further erode if claims administrators shield actual or purported plan documents, which they communicated and represented to plan participants as the legal basis for their benefits determinations, from beneficiary review and scrutiny.

An entirely workable scenario between a plan beneficiary, plan administrator and claims administrator follows from the Seventh Circuit's decision and is grounded in ERISA law and DOL guidance. A plan administrator that contracts with a claims administrator must require that all documents related to claims and claims decisions be available and produced upon request to the plan administrator. Claim or benefits denials generated from claims administrators must specifically reference the section of the SPD that authorizes such action. Thus, language or provisions that act to provide the legal basis to deny coverage outside the four

corners of the SPD are invalid. Plan administrators have a duty to ensure that third party claims administrators do not stray from the terms of the SPD or the GSA.

Plan administrators cannot abdicate their fiduciary responsibilities to plan beneficiaries based on a purported lack of control or access to documents. Plan administrators have ample opportunity to draft the contractual provisions necessary to protect their oversight role and responsibilities to plan beneficiaries. Here, CIGNA's benefits interpretation documents provided substantially more information relevant to Ms. Mondry's eligibility for the benefits claimed than did the SPD. This included: a list of conditions for which speech therapy is considered by CIGNA to be medically necessary; types of documentation that may support the necessity of speech therapy; and, a definition of "medically necessary" that is far different from that found in the SPD. Had American Family acted promptly in a ministerial role over its agent, CIGNA, to address the use of documents outside the scope of the SPD, Ms. Mondry's forty-one requests for plan documents would not have been necessary. American Family could and should have promptly exercised authority over the process and its agent, CIGNA.

This case stands for affirming the transparent process laid out by Congress under §1024(b)(4) for plan beneficiaries to obtain vital plan documents and, as in this case, documents represented as plan documents. The people of this nation will never be able to enforce the rules of their health plans if they cannot obtain and review the documents that purport to contain those rules. A decision to accept review in this case will have a significant impact not just on the petitioner and

respondent but on a large class of plan beneficiaries, plan administrators and claims administrators across the country where over 55% of the employed population has insurance in self-funded ERISA plans.[17]

B. The Seventh Circuit's Holding Promotes Transparency in Health Reform

The country has embarked upon a national debate over health care and the equitable treatment of people in need of care and coverage. An important tenet in this debate must be the complete access to and enforcement of the rules of coverage. Most debate participants agree that a transparent process is paramount to building public trust and confidence in the system. One of the fundamental rights of health care consumers is to understand the terms of their benefits and coverage. Plan beneficiaries rely on plan administrators to ensure their rights and interests are protected throughout the claims adjudication process. The transparency of that process can only be preserved if plan administrators are held to their duty to ensure their claims process is governed by the terms of the documents provided to plan beneficiaries. If administrators stray from the SPD, they must deliver to the beneficiary the documentation cited as controlling the claim.

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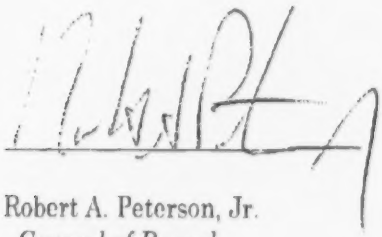
[17] Only 6 million Americans were insured through self-funded plans when ERISA was enacted. The number of covered workers that are in a plan that is completely or partially self-funded has remained stable over the last few years. Slightly more than half (55%) of covered workers are in a self-funded plan. Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2007, 147 (2007).

Here, CIGNA cited the CRT and BIRT as dispositive of Ms. Mondry's claim. American Family, on notice of Ms. Mondry's multiple requests for these two documents, failed to investigate the authority of these documents over her claim and abandoned its responsibility as the plan administrator to police its agent, CIGNA. Despite representation by counsel for much of the process, Ms. Mondry was thrust through a harrowing, exhausting, Kafkaesque experience. One can only imagine the challenge for an unrepresented plan beneficiary, either sick or caring for an ill family member, to navigate the labyrinth Petitioners propose. In this case, the plan documents produced by American Family's agent CIGNA were ultimately exposed as lacking the authority to deny Ms. Mondry's son the speech therapy benefits he was due under the terms of the SPD. But, the damage was already done. American Family's inaction and acquiescence over a twenty-seven month period blithely flouted the authority of §1024(b)(4) despite repeated admonitions from Ms. Mondry. After nearly three years and forty-one requests for plan documents, Ms. Mondry finally acquired the information necessary to expose the complacent, misleading tactics of American Family.

CONCLUSION

This case represents an opportunity for the Court to enforce the clear and transparent benefits administration envisioned under ERISA by requiring plan administrators to disclose plan documents that outline the rights, benefits, and responsibilities of plan participants. Here, too, the Supreme Court can harmonize the law of required plan document disclosures among the First, Second, Fourth,

Sixth, Eighth and Ninth Circuits with the interpretation advanced by the DOL. Ms. Mondry respectfully requests that this Court grant certiorari to make clear that §1024(b)(4) requires the disclosure of plan documents expressly cited as controlling a plan beneficiary's claim.



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